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MONTANA'S INITIATIVE FOR THE ABATEMENT OF MORTALITY IN INFANTS

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ACCOMPLISHMENTS and RECOMMENDATIONS
December, 1990

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INTRODUCTION

The death of an infant is a profound human tragedy. Each year, some 40,000 American infants die before their first birthday. The rate of infant death is a major standard, accepted throughout the world, for measuring a society's overall health status and a nation's health and well being. As a society, we have made great gains in ensuring the survival of our infants and improving the quality of their lives. However, **among industrialized nations, the U.S. has one of the highest rates of infant mortality (9.9 deaths per 1,000 live births in 1988)**, ranking 19th behind such countries as Singapore, Hong Kong and Spain.

The high U. S. mortality rate is brought about largely by low birthweight (LBW) babies being born too soon or too small (from prematurity or from not growing adequately during pregnancy), and by increases in infant death rates during the first year of life (postneonatal mortality). During this period babies are most vulnerable to damaging effects of poverty and inadequate health care.

THE MIAMI CONCEPT

Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) is a concept developed to address issues critical to the well being of pregnant women, women anticipating pregnancy, and children in Montana. Despite our seemingly "low risk" primarily Caucasian population, in 1987 Montana ranked 29th in the nation in infant mortality, down from 20th in 1986. The major reason Montana babies die in the first year of life is low birthweight. The most effective tool to decrease the incidence of low birthweight is early, comprehensive and continuous prenatal care.

The goals of the MIAMI Act as passed by the 1989 Montana Legislature are:

- assuring that mothers and children, in particular those with low income or with limited availability of health services, receive access to quality maternal and child health services;
- reducing infant mortality and the number of low birthweight babies; and
- preventing the incidence of children born with chronic illnesses, birth defects, or severe disabilities as a result of inadequate prenatal care.

The Montana Department of Health and Environmental Sciences (MDHES) was directed to provide the following services as part of the MIAMI Project:

- infant mortality review

- low birthweight prevention
- assistance to low income women and infants in gaining access to prenatal care, delivery and postpartum care, and
- referral of low-income women and children to other programs to protect the health of women and children.

Governor Stephens appointed a seven-member MIAMI Advisory Council to consult with the Department of Health and Environmental Sciences "on matters pertaining to the MIAMI project and to make recommendations regarding maternal and child health services."

Council members include:	Representing:
• Marietta Cross, R.N., Chairman Community Medical Center Missoula	As President of Healthy Mothers, Healthy Babies, a nonprofit child health organization
• Jeffrey P. Hinz, M.D. Great Falls Clinic Great Falls	The medical profession
• Cherry Loney, Health Officer Cascade City-County Health Department Great Falls	Local health departments
• Lil Anderson, R.N. Associate Director Yellowstone City-County Health Department Billings	Local service provider
• Nancy Colton Bozeman	A support group for parents
• J. Dale Taliaferro, Administrator Health Services Division DHES, Helena	The Department of Health and Environmental Sciences
• Nancy Ellery, Administrator Medicaid Services Division DSRS, Helena	The Department of Social and Rehabilitation Services

The MIAMI Advisory Council held its first meeting on December 7, 1989. Subsequent meetings

were held on January 30, April 3, June 19, September 25, and November 9, 1990.

The report which follows highlights the four components of the MIAMI project. For each component, an introductory section, **Background,** defines the scope of the problem or issue prior to MIAMI and the purposes and objectives of the interventions and approaches used. Where applicable, a section describing **Outcomes** defines what was accomplished, what was evaluated and how, and the results of the evaluation. **Recommendations** about the entire project and the application of findings to future funding, program activities and state priorities are presented as a final section.

LOW BIRTHWEIGHT PREVENTION

BACKGROUND -- BEFORE MIAMI

No period of life is more important to good health than the months before birth. The prenatal period can be the starting time for good health or it may be the beginning of a lifetime of illness and shortened life expectancy. Low birthweight (LBW) occurs in about 7 percent of all live births in the United States and is the greatest single hazard to infant health. This dangerous condition has been linked to several preventable risks, including lack of prenatal care, maternal smoking, use of alcohol and other drugs, and pregnancy before age 18.

Low birthweight (5# 8 oz. or less) is the major reason Montana infants die in their first year of life. Inadequate prenatal care has been identified as the leading cause of low birthweight. Many Montana women lack appropriate, affordable, accessible and acceptable prenatal care.

A major barrier to early and continuous prenatal care is lack of access to physicians and other health care providers. The difficulty in finding doctors for Medicaid-eligible pregnant women has been heightened by low reimbursement rates (Montana physicians are reimbursed $756 - $806 for total obstetrical care, including prenatal, labor and delivery, and postpartum care -- approximately 42% of the typical charges) and administrative paperwork. The high cost of malpractice insurance, the rapid decline in the number of physicians providing obstetrical care, and the closing of rural hospitals or their obstetrical services have made access to health care even more difficult for women already affected by lack of transportation or knowledge about what to do or where to go.

Repeatedly, studies have shown that it is ultimately more expensive **not** to provide maternity care. Increased health care costs associated with LBW affect not only the family but also society. In 1988, in Montana, $4.2 million or half of the total Medicaid delivery budget of $5 million dollars was spent on only 4 percent of the births. A majority of those births were low birthweight and could feasibly have been prevented with regular prenatal care. Medicaid pays and average of $19.48 for each prenatal visit. By comparing that cost to neonatal intensive care costs of $610 - $2000 **PER DAY** it becomes apparent that money used to forestall problems is well spent.

The Institute of Medicine concluded in 1985, in their landmark study Preventing Low Birthweight, that every dollar spent on the provision of comprehensive prenatal care services to high-risk, low income women could save $3.38 for the initial hospitalization expenses in newborn intensive care units (NICUs). This analysis considered **only** intensive care costs; it did not take into account the possible long-term health care costs and other financial burdens affecting the child, family and society. These include costs for nonmedical expenses, such as special education, lifelong disability and limited employment and parenting potential in adulthood for the LBW infant, as well as the costs for work loss by the parents.

The Office of Technology Assessment has studied the potential effectiveness of prenatal care for all pregnant women living in poverty. Its findings indicate that for every instance of low birthweight averted by prenatal care, the United State health care system saves between $14,000 and $30,000 in health care costs associated with this condition.

Demonstration Projects Selected

Plans for the first community based low birthweight prevention projects were finalized following a 1986 Governor's Conference on Health Promotion and Disease Prevention. Four sites (Yellowstone, Gallatin, Beaverhead, and Missoula) were selected as demonstration project sites. Each of the four sites chose a different approach to the problem of preterm labor and low birthweight prevention: education of health professionals, outreach to a targeted population with a documented 12.9% LBW rate, home visits by public health nurses for teaching and health status (pregnancy status) monitoring, and expansion of existing high risk infant followup programs to target their moms, i.e., high risk pregnant women.

All women admitted for service were (and continue to be) screened with a medical risk assessment tool which helps identify women at risk of pre-term labor. Based on the work of Dr. Robert Creasy, this tool appears in Appendix A.

At the conclusion of the two year demonstration period, nurse coordinators with the four projects, along with DHES staff and others, evaluated what "worked". Interest in prevention of low birthweight resulted in additional sites being funded and in reallocation of local funds to better meet the needs of pregnant women. Clearly, the message that pregnancy outcomes could be improved by services which educated women about preterm labor, linked women with other social service agencies, and increased women's ability to access medical prenatal care was being heard.

The "Montana Model"

Defining "what works" resulted in the care coordination model for low birthweight prevention which appears on the next page as Figure 1. Care coordination, as practiced by the Low Birthweight Prevention projects, expands on traditional definitions of case management. Care coordination provides those services needed to ensure optimal pregnancy outcome and reduce infant mortality. The approach is based on **screening** pregnant women for medical and/or psychological risk of preterm labor or low birthweight; assisting these women to **access** prenatal care, preferably during the first trimester of pregnancy; **education** about signs and symptoms of preterm labor; **education and assessment** of the use of alcohol, tobacco and other drugs; **assessment** of nutritional status and risk; referral to WIC, other agencies and programs for services, treatment, and other assistance. Additionally, the model identifies the range of "moderating variables" that individualize case managed care.

A public/private funding coalition supported efforts to reduce infant mortality in the early years and included MDHES, the Montana Perinatal Association, the March of Dimes, the Developmental Disabilities Planning and Advisory Council (DDPAC), and Healthy Mothers, Healthy Babies: The Montana Coalition. Representatives from this funding coalition became the first advisory committee for low birthweight prevention in Montana.

Figure 1

M I A M I
Care Coordination Modal for
Low Birthweight Prevention
in Montana

Intervention or Process Objectives	Potential Moderating Variables	Outcomes or Short-term Objectives	Impact or Long term Objectives
All women will be screened for risk of preterm labor at initial visit.	age parity	Women at risk of pre-term labor will be identified and educated.	
All women will receive education about preterm labor (PTL).	pre-pregnancy weight pattern of weight gain during pregnancy	Women will be able to identify signs and symptoms of PTL and appropriately seek medical treatment as indicated by symptoms.	Increase number of babies born ≥ 2500 G or 5.5 #.
All women will be assessed for social risk.	marital status		Increase number of babies born ≥ 37 weeks gestation.
All women will be assisted with access to early and continuous prenatal care as needed.	education county of residence race/ethnicity	Women will receive counseling, information and referrals as appropriate.	
All women will be assessed for nutrition risk.	lifestyle socioeconomic status	Women at increased risk of parenting skill deficits will be identified and monitored or referred.	
All eligible women will be referred to WIC.	transportation genetic risk nutritional risk/status	Women will receive early prenatal care, goal of continuous, consistent prenatal care will be met.	60% of women will access prenatal care. Meet Year 2000 National Objectives.
All women will be screened for alcohol, tobacco or other substance use.	child care previous obstetrical history occupation	Women will have a weight gain > 24 lb. or as appropriate for prenatal weight and pattern of weight gain.	
All women will be educated about substance use and pregnancy.			
Women who need treatment and further education services about substance use/abuse will be referred to appropriate agencies.		Women will decrease substance use, drinking and smoking during pregnancy and beyond.	Reduce number of infants with fetal alcohol syndrome (FAS).

The MIAMI Project

Passage of the MIAMI legislation helped to focus attention of state policy makers and leaders on the widespread problem of low birthweight. The seven Low Birthweight Prevention Projects across the state are located in counties where approximately 50% of the state's births occur.

Approximately one-fourth of the pregnant women in the seven sites are eligible for and receive care coordination services. Current locations of low birthweight prevention projects include city-county health departments and hospitals in the following counties:

- Cascade (Better Beginnings),
- Gallatin (Prevent Prematurity),
- Lewis and Clark (Healthy Pregnancy Services),
- Missoula (Access-Links),
- Yellowstone (Better Babies - Deering Community Health Center),
- Marcus Daly Memorial Hospital (Access-Links of Ravalli County) in Hamilton, and
- Beaverhead County Health Department/Barrett Memorial Hospital (Healthy Pregnancy Project) in Dillon.

The map below shows the location of the LBWP projects.

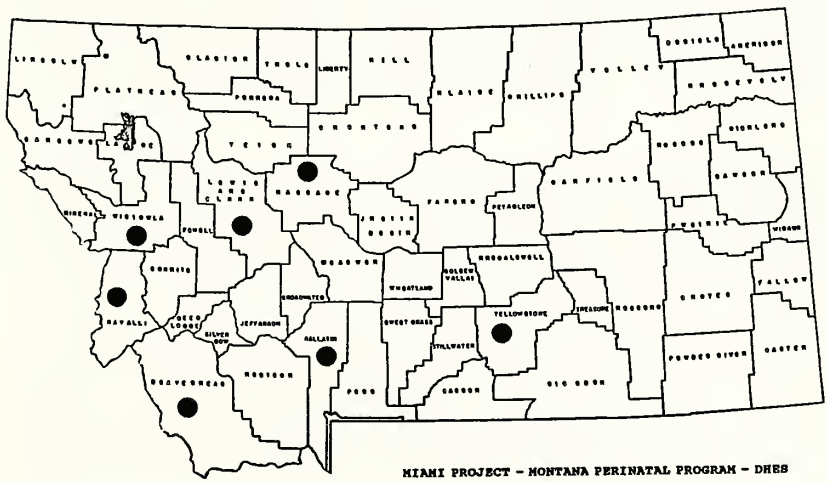


Figure 2. Location of Low Birthweight Prevention Projects, FY '90

Critical to the success of these projects has been the development of local coalitions which include public health, private medicine, hospitals, WIC, social services, and other official and voluntary agencies. Expansion of the LBWP projects to 16 proposed sites will provide case managed services in areas where 95% - 98% of Montana's births occur.

OUTCOMES

The Montana model has worked well. Women surveyed about their care in the local projects are overwhelmingly "highly satisfied" with the care received. Women are accessing medical prenatal care earlier, many within the first trimester. Physicians in many parts of Montana are more willing to provide care to Medicaid-eligible women whom they know have been seen and have received counseling and education from LBWP project staff. More importantly, women, some of whom are displeased at being pregnant become involved in their care. A brief synopsis of a young woman's situation illustrates how care coordination was successful in one project.

> "A 28 year old female was referred to [the project] at 25 weeks gestation, shortly after being diagnosed with twins. . . . The client was determined to be at very high risk for preterm delivery, scoring 20 points on the assessment screening where a minimum of 10 points defines high risk.
>
> Her risk factors included: twin pregnancy, history of premature labor in first pregnancy controlled by medication, premature delivery of a 4 pound infant requiring a one month NICU stay with the second pregnancy, obesity, a 3 pound total weight gain, placenta previa with this pregnancy, a heart condition controlled by medication, and three children at home, ages 2, 3 and 8. Other objective findings included a low socioeconomic status, an unresponsive attitude towards our proposed teaching and apparent depression about her situation. Cooperation from this client was questionable, although she agreed to participate in [the Program]."
>
> The patient was seen by the public health nurse every other week with intensive teaching and support in an attempt to avoid delivery of the babies earlier than 36 completed weeks of pregnancy. Initially the client was unwilling to become involved, but as she saw she did have some control over the outcome of this pregnancy, she began reading about labor and delivery at the library and faced the nurse with some very specific questions about the risks involved with twins.
>
> At 34 weeks the patient was placed on oral medication to control contractions. She made it very clear that she could not afford the medication. The project was able to pay for her medication, and with frequent visits and lots of encouragement, she made it to 37 weeks. Within one week of being off medication she delivered healthy twins with weights of 5# 10 oz. and 4# 2 1/2 oz. The infants went home from the hospital with their mother, requiring no time in the NICU.

Nearly 1350 women received services from the projects in the past year. A total of $152,150 for the 7 projects was administered by the Montana Perinatal Program during FY '90. This does not include funding from local health departments and hospitals in support of these projects. Sources of state-administered funds included Federal Maternal and Child Health and Preventive Health Block Grants. The cost per client in state-administered funds was $113.46.

In Montana, a low birthweight baby costs a minimum of $610 per day and may be hospitalized 7 to 20 days on average. A very low birthweight survivor (one who eventually goes home)

averages $31,000 to $71,000 in hospital costs alone. Very low birthweight infants are more likely to have problems requiring lifetime care, which can average $415,588.

In examining the impact of the program, several questions must be considered.

- Is the program effective?
- Has it produced the expected change in clients/target communities?
- Who is the population served: at-risk? teens? ethnic groups?
- Were pregnancies carried longer because of early identification of signs and symptoms of pre-term labor?
- How many women were eligible for WIC? Medicaid?
- What are the cost savings generated by Project efforts?

To track the outcomes of pregnancies of project clients, DHES and the local project coordinators worked with Mr. Tom Lacher of the federal Centers for Disease Control to develop the Low Birthweight Prevention Projects Flowchart, which appears as Appendix B. Data for FY 1990 are presented on this chart, reflecting the seven current projects.

Several sites were able to determine the rate of low birthweight among client populations prior to beginning a LBW prevention project. Based on current LBW rates, the number of low birthweight babies **prevented** were calculated for four sites. Potential savings by these prevention efforts are shown in Table I below.

Table I

Cost Savings of Four Projects Through LBW Prevention

Data Source: Project proposals and annual reports

PROJECT	PROJECTED LBW BABIES*	ACTUAL LBW BABIES	NUMBER LBW BABIES PREVENTED	ACUTE CARE SAVINGS●
A	9	5	4	$ 130,232
B	2	1	1	32,558
C	22	9	13	423,254
D	19	12	7	227,906
	TOTAL POTENTIAL SAVINGS			$ 813,950

* = Number of lbw babies who would have been born to FY '90 LBW prevention projects clients if calculated at pre-project LBW rates

● = Figures based on Montana SRS "High Cost Medicaid Infants" study, January, 1989

Consistent with the findings in other states, projects must be in existence for two to three years

in order for their impact to be felt. Table II compares LBW rates in five of the seven counties where projects are located with LBW rates pre-project and at the end of fiscal year '90.

The percentage of babies born with birthweights below 5½ pounds ranged from 5.8% to 12.9% before low birthweight prevention projects were begun. In the five projects which have been operational for two or more years, these numbers have dropped to a range of 3.1% to 5.6%. In two instances, the percentage of low birthweight in the project at the end of FY 1990 is lower than the county percentage at the end of calendar year 1989. The 1989 LBW percentage for Montana was 5.5.

Table II

Rate of LBW by County and Project Site at
Project Start and at FY '90 End

Project	Start Date	County LBW Rate, 1985	County LBW Rate, 1989	LBWPP Site LBW Rate, 1985	LBWPP LBW Rate FY 1990
A	7/86	4.2	6.2	5.8	3.1
B	8/86	4.6	4.7	9.1	4.9
C	10/86	5.9	3.9	12.9	5.5
D	10/86	5.8	6.1	9.1	5.6
E	3/88	7.5	3.8	*	5.5
TOTAL		28.0	24.7	36.9	24.6
AVERAGE		5.6	4.94	9.2	4.92

* Data not available
LBW = less than 2500 grams or 5 lbs., 8 oz.
County rates for calendar years, resident data. Low birthweight prevention projects (LBWPP) rates for calendar year (1985) and for fiscal year '90 -- July 1, 1989 through June 30, 1990.

Demographic characteristics of the women seen by the projects give a view about the population accessing these services. Typically, the client range includes pregnant women of all ages, with a tendency toward younger populations. Projects located in counties with ethnic diversity serve a larger percentage of minorities than are represented in the state population as a whole.

Whether the project was successful in terms of being cost effective is a concern of all who are requested to fund "prevention" programs. In terms of the state-generated or -controlled dollars, the projects have been exceedingly low cost and have prevented long term costs.

A normal pregnancy lasts 38-42 weeks; infants born at less than 37 completed weeks of pregnancy are considered "premature". For each week prematurity is prevented, a company may save as much as $10,000 in insurance costs [1]. Savings to taxpayers may be as great for

women whose maternity costs are covered by Medicaid.

Schwartz, in her article titled "What Price Prematurity?" [2] calculated costs saved by shifting of infants into the next higher birthweight category. Postponing delivery through monitoring and early detection of two 800 gram infants (approximately 1 #, 12 oz.) **even for one week** may result in savings of up to $33,700. These figures underscore the importance of educating pregnant women about the **signs and symptoms of preterm labor**, as well as all aspects of pregnancy.

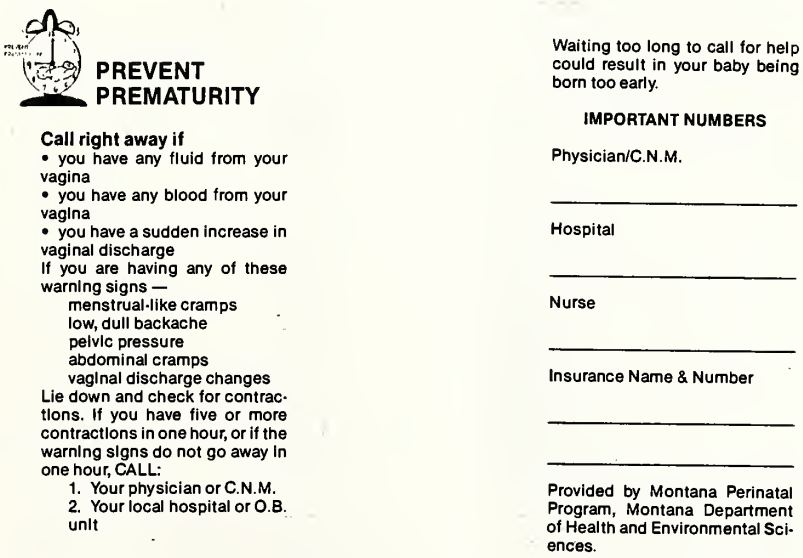
A major effort by the Low Birthweight Prevention Projects has been the education of clients and their support people about the signs of preterm labor, as well as all other aspects of pregnancy. Creative approaches to educating clients about preterm labor have been developed in the low birthweight prevention projects.

The success of the education effort is demonstrated by one project, which reports:

> "Kate" went into preterm labor at 25 weeks gestation due to premature rupture of the membranes. She was hospitalized for a total of ten days and was sent home on oral [medication] and strict bedrest for the duration of pregnancy. . . . The community health nurse provided support and education throughout "Kate"'s difficult pregnancy. . . . "Kate" delivered a healthy baby at 39 weeks gestation. . ."

Health care cost savings could approach one quarter of a million dollars for this infant.

Wallet size cards which list the signs of preterm labor were produced by one local project and have been made available to all projects. This card is reproduced below.



PREVENT PREMATURITY

Call right away if
- you have any fluid from your vagina
- you have any blood from your vagina
- you have a sudden increase in vaginal discharge

If you are having any of these warning signs —
- menstrual-like cramps
- low, dull backache
- pelvic pressure
- abdominal cramps
- vaginal discharge changes

Lie down and check for contractions. If you have five or more contractions in one hour, or if the warning signs do not go away in one hour, CALL:
1. Your physician or C.N.M.
2. Your local hospital or O.B. unit

Waiting too long to call for help could result in your baby being born too early.

IMPORTANT NUMBERS

Physician/C.N.M.

_____

Hospital

_____

Nurse

_____

Insurance Name & Number

_____

_____

Provided by Montana Perinatal Program, Montana Department of Health and Environmental Sciences.

Figure 3. Prevent Prematurity Wallet Card

Successful as the care coordination model for low birthweight prevention has been, it does not tell the entire story. Referrals to the projects have increased, both in number of women referred and source. Community changes are evident in each area where a low birthweight prevention project has been in existence for two or more years. Community coalitions of persons from many agencies and organizations concerned with improved care for mothers and children are working together.

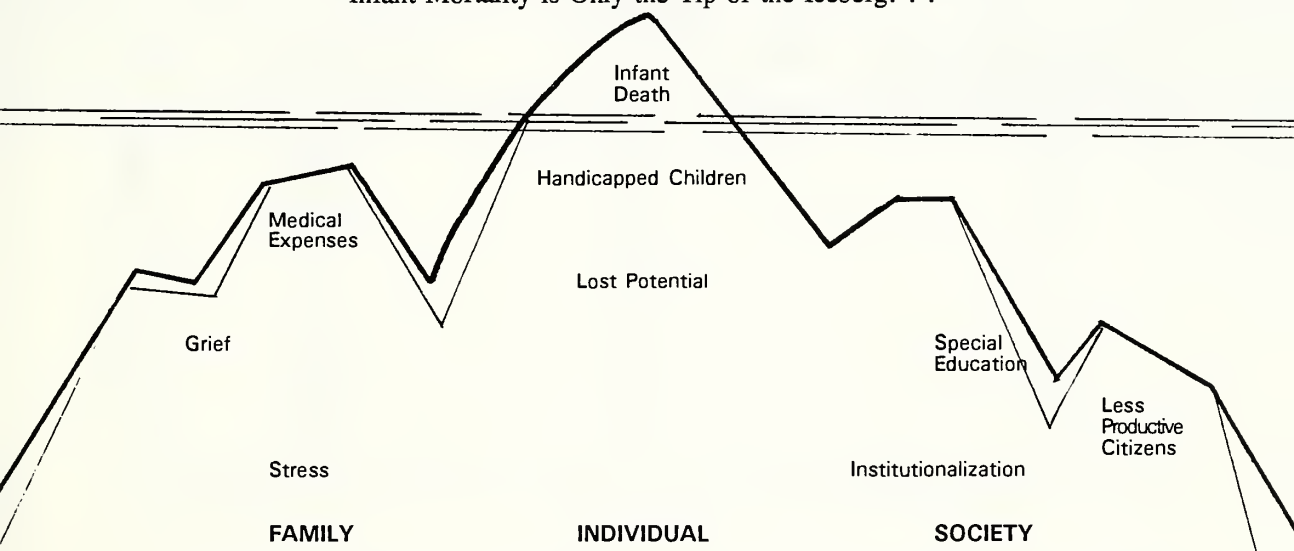
INFANT MORTALITY REVIEW

BACKGROUND

Infant mortality has a major impact on the lives of all Montanans. The tragedy of an infant's death, while devastating to the family and friends, is actually only the tip of the iceberg. (see Figure 4). Family stress, medical costs, special education needs, and lost potential affect society in many other ways. The problem requires careful study so that not only are the actual deaths reduced, but other consequences decreased.

Figure 4.

"Infant Mortality is Only the Tip of the Iceberg. . ."



Infant death is like the tip of an iceberg. It is easy to see and its cost is measured in lives lost. Handicaps occurring in the perinatal period are less obvious but just as costly to individual, families and society.

QUALITY PRENATAL, DELIVERY AND NEWBORN CARE CAN REDUCE INFANT DEATH AND DISABILITY ASSOCIATED WITH PREGNANCY AND EARLY CHILDHOOD.

- adapted from South Carolina -

Fetal and infant mortality are more than a medical problem; socio-economic impacts on infant mortality may not be ignored. According to a 1986 Innovations report, government has begun to enter the arena of health care delivery to infants and pregnant women . . . "because there are classes of people who are in great need of perinatal and maternal care that is unavailable due to cost, ignorance, or lack of accessibility." The report further states that "the mere presence of medical services does not necessarily mean that they are available and will be used by all classes of people. Indeed, the primary obstacles for indigent patients are cost and lack of accessibility."[3]

What are the obstacles resulting in Montana's high mortality rates? How much do we really know about pregnant women's perceptions of health care, and reasons for their health care practices? But most importantly, **WHY ARE MONTANA'S BABIES DYING?**

These questions are the impetus for Montana's ongoing work on infant mortality. Montana's infant mortality rate of 11.3 in 1989 is our highest rate since 1980, representing a 31 per cent increase from 1988. While this figure may be only a "blip" on the statistical screen (the 5 year average infant mortality rate is 9.8), it does serve as a reminder that infants' deaths in our state are still a major problem. Montana's Native American infant mortality rate of 25.2 in 1989 is extremely high, rivaling the rates reported in minority populations in large urban settings in other states.

Table III

Montana Births, Infant Deaths and Infant Mortality Rates

1980-1989

YEAR	LIVE BIRTHS	INFANT DEATHS	INFANT MORTALITY RATE*
1989	11,667	132	11.3
1988	11,682	100	8.6
1987	12,239	121	9.9
1986	12,728	122	9.6
1985	13,497	139	10.3
1984	14,141	125	8.8
1983	14,054	126	9.0
1982	14,538	147	10.1
1981	14,309	153	10.7
1980	14,208	176	12.4

* Per 1,000 live births

The initial response to dismiss these figures as a result of low numbers or other reasons unique to Montana must be suppressed. North Dakota, a bordering state with many characteristics similar to Montana, including weather, access to health care, ethnic groups and overall population, had the best ranking in infant mortality among the 50 states in 1986, compared to Montana's dismal 20th ranking.

In recent years, Montana addressed the need to positively affect infant mortality at a 1986 Governor's conference. This conference, which reviewed the 1990 Objectives for the Nation, developed 1990 objectives for Montana. These were published in the conference report, Montana Action Plan. None of the objectives related to infant mortality have been met (see Table IV).

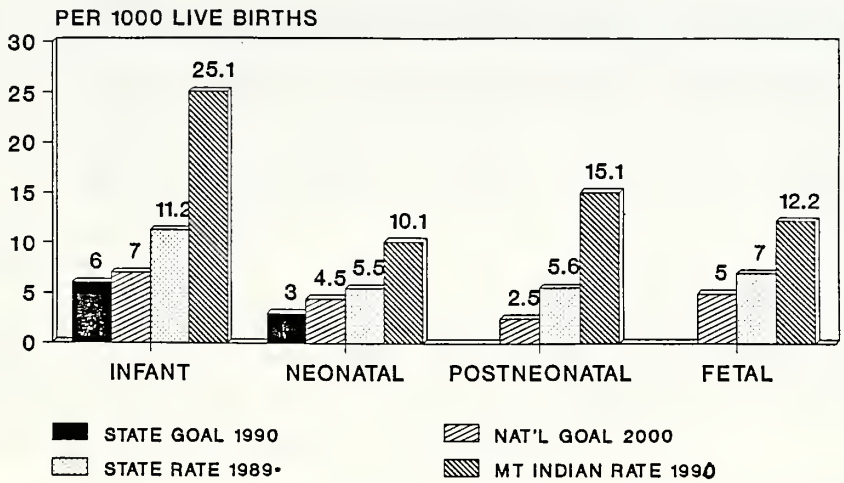
The 1989 Indian infant mortality rate of 25.2 is over two times higher than the combined state rate. In addition, the ratio of fetal deaths to infant births continues to be much higher in the

Indian population as compared to the Caucasian.

TABLE IV

FETAL AND INFANT MORTALITY

Rates and Goals



* Includes Caucasian and Native American

Legislation creating the MIAMI Project (Appendix C) mandates DHES to conduct an Infant Mortality Review (IMR). IMR is defined as "a process for examining factors which contribute to infant death through a systematic evaluation of individual cases in order to identify potential opportunities to improve maternal and child health" (William Sappenfield, M.D.)

Prior to this mandate, the Montana Perinatal Program (MPP), recognizing the importance of examining infant mortality, contracted with the University of Montana Center for Population Research to conduct a retrospective study of infant mortality. Using matched birth/death certificate files, over 84,000 cases have been examined by Drs. Fred Reed and William McBroom, Director and Assistant Director, respectively, of the UM Center. Their findings provided DHES with valuable direction for infant mortality review as well as raising even more questions about the causes for infant mortality.

The goals for the Infant Mortality Review are to:

GLOBAL

- Reduce infant, neonatal, and postneonatal mortality rates, and the fetal death rate to levels equal to the National Year 2000 objectives during the next 10 years.

SPECIFIC

- Gather data which will identify access problems and social impacts on infant and fetal death.
- Compare the incidence of infant and fetal mortality, and maternal access problems in sites with Low Birthweight Prevention projects to sites without those projects.
- Monitor differences in mortality rates between Caucasian and Native American population.
- Develop recommendations for program changes/additions to address identified gaps or deficits in care.

OUTCOMES

In July, 1990, infant mortality review which reflects Dr. Sappenfield's definition requiring individual case review began. Montana's IMR is a descriptive study. Three counties are participating in 6 month pilot project: Cascade. Lewis and Clark, and Missoula. The counties have actively participated in the IMR planning and are supporting the infant mortality review process by funding data collectors. One county is also receiving support from a local hospital in the form of personnel to participate in data collection.

Some concerns have been voiced about the lack of a specified Indian population (i.e., reservation) in the pilot project. The counties participating in the pilot project are doing so on a volunteer basis, and were included due to their ability to fund the process and their size, which allowed for a larger sample.

MEDICAID OPTIONS FOR PREGNANT WOMEN

BACKGROUND

In 1984, 17 percent of women of reproductive age lacked insurance to pay for prenatal care and another 9 percent had only Medicaid coverage, according to a study based on census data [4]. As of 1985, the United States had made virtually no progress in meeting the goals set in 1980 by the Surgeon General for

- reducing the percentage of babies born with low birthweight to no more than 5 percent of live births and
- ensuring that 90 percent of all pregnant women obtain care within the first 3 months of pregnancy.

As of June, 1987, 19 states had expanded Medicaid eligibility to pregnant women with incomes of up to 100 percent of the federal poverty level, an option authorized by the Omnibus Budget Reconciliation Act (OBRA) of 1986. States doing so could significantly reduce lack of money as a barrier to prenatal care. No states at that time had implemented presumptive eligibility -- providing care while a woman's application for Medicaid is being processed -- also allowed by OBRA '86.

The MIAMI Act permits the Montana Medicaid program to include all health care except delivery for pregnant women during a presumptive eligibility period.

In April, 1990, Medicaid eligibility was expanded for pregnant women and children under the age of six with incomes up 133% of the federal poverty level. This means that a pregnant woman with one other child in the home could have income up to $1,170 per month. At that time the Medicaid Services Division in the Montana Department of Social and Rehabilitation Services (DSRS) estimated that 31.5% of Montana births could qualify for Medicaid coverage.

OUTCOMES

Under the auspices of the Governor's Human Services Sub-Cabinet, a subcommittee on Maternal-Child Health was appointed. Initially mandated to develop a report of the status of Maternal and Child Health initiatives and programs, along with recommendations, this subcommittee, chaired by Nancy Ellery, Administrator, Medicaid Services Division, DSRS, went beyond its original assignment and has continued to meet regularly. Kids Count, the report of the subcommittee, was published in April 1990, and has issued one updated Status Report in October 1990. Members of the subcommittee represent the Departments of Health and Environmental Sciences, Social and Rehabilitation Services, Family Services and Institutions, along with the Office of Public Instruction, Indian Health Services, and the Montana Medical Genetics Program at Shodair Hospital.

GOALS

- Increase the eligibility income level to 133% of the federal poverty level. **This provision was implemented on April 1, 1990.**

- Implement **presumptive eligibility**. Presumptive eligibility allows qualified providers to certify Medicaid eligibility for pregnant women while a formal application is being processed. This option is scheduled for implementation on January 1, 1991.

- Implement **continuous eligibility**. Continuous eligibility allows Medicaid eligibility to continue in cases where the pregnant woman would no longer be eligible for financial assistance based on a change in income. This option is also scheduled for implementation on January 1, 1991.

- Train eligibility staff to expedite handling of applications for pregnant women. Some local areas have been able to implement strategies that identified applications from pregnant women, such as Missoula City-County Health Department's use of a footprint stamp to identify their referrals of pregnant women to the local Human Resources office. **Training of eligibility staff has occurred statewide.**

- Study feasibility of outstationing eligibility staff. **This proposal has been studied with the conclusion that it is not feasible to implement on a statewide basis at this time.**

- Increase eligibility income level to 185% of the federal poverty level. (Would require state legislation)

- Increase Medicaid reimbursement for delivery services to 90% of the Blue Cross Blue Shield prevailing rate.

- Increase participation of alternative mid-level providers including nurse practitioners, certified nurse mid-wives and others.

- Reimburse rural health clinics and federally qualified health clinics for ambulatory services.

- Implement targeted case management as an optional Medicaid service.

PUBLIC EDUCATION -- "BABY YOUR BABY"

BACKGROUND

National studies show that the leading cause of death among infants less than one year of age is low birthweight. Medical experts agree that low birthweight and its complications can be largely prevented if the expectant mother receives prenatal care during her first trimester and at regular intervals thereafter until the birth of her child.

Nearly one quarter of all pregnant women in American fail to see a health care professional prior to their child's birth. Low income, non-white women and teen age girls are most likely to obtain inadequate prenatal care.

A key element of the MIAMI project is public education. The Baby Your Baby (BYB) campaign is designed to educate and motivate expectant mothers (and those who care about them, i.e., parents, relatives, friends) to enroll in a medical support program in the first 3 months of pregnancy.

GOALS

The objectives of this outreach campaign are:

- To increase the number of women seeking prenatal care during their first trimester.
- To reduce infant mortality and morbidity.
- To reduce the number of low birthweight babies.

The campaign, **"Baby Your Baby"**, is a two year community outreach and public awareness effort involving a multi-media approach to selected target audiences in both urban and rural areas. This multi-faceted media campaign is directed to high risk women, and secondarily to all women of child bearing age. Specific target groups for the campaign include:

- teenagers
- alcohol and/or drug addicted or affected women
- Native American women
- low socio-economic groups, including the homeless

The statewide multi-media campaign includes:

» television and radio public service advertising
» print advertising
» billboards
» posters

- » brochures
- » newspaper tabloid
- » video documentaries
- » 1-800 toll free information line
- » television news series and insert segments
- » seminars
- » comprehensive publicity coverage
- » incentives
- » referrals

To attract expectant mothers, an incentive program has been developed. Incentives serve the dual purpose of encouraging expectant mothers to enroll in the program, and also provide for tracking their participation. In other states the incentive element significantly improved response from target groups.

A broad-based voluntary steering committee has been formed to assure that all target populations are reached. Several subcommittees are focusing on specific elements. An executive committee provides overall guidance and has final approval of all campaign elements. The executive committee is comprised of groups and individuals who have significant contractual or financial arrangements with the project.

PUBLIC/PRIVATE PARTNERSHIP

The Baby Your Baby campaign is a true public/private partnership. DHES has contracted with HMHB -- The Montana Coalition to develop the campaign. Funding for the first year is essentially complete. The cost of the campaign is underwritten by sponsors from both the public and private sector. The campaign will provide the underwriting partners with two years of high visibility throughout the state.

Sponsors to date include the following:

- ♥ Blue Cross/Blue Shield of Montana
- ♥ Montana Department of Health and Environmental Sciences
  - Family/MCH Bureau
  - Montana Perinatal Program
  - WIC Program
  - Immunization Program
- ♥ Montana Department of Social and Rehabilitation Services
  - Developmental Disabilities Division
  - Medicaid Division
  - Child Support Division
- ♥ Healthy Mothers Healthy Babies -- The Montana Coalition
- ♥ The Doctors' Company
- ♥ Dr. Leonard Kaufman

- ♥ Montana Big Sky Chapter March of Dimes
- ♥ Montana Genetics Program of Shodair Hospital
- ♥ Children's Trust Fund
- ♥ Montana Area Health Education Center
- ♥ Montana Department of Family Services

OUTCOMES

Securing funding and developing contractual arrangements has occupied a major portion of time during the past year. The following agreements have been developed:

- DHES with HMHB to conduct the educational campaign, in response to a Request for Qualifications;
- DHES with DSRS to transfer the contribution from the Developmental Disabilities Division to DHES, then to HMHB;
- DHES with DSRS to match private sector donations with Federal Medicaid dollars, transferred to DHES, then to HMHB;
- HMHB with KTGF, ABC affiliate, Great Falls, as the program originator and network anchor. Network affiliates have been identified in Billings, Helena, Bozeman, Butte, Missoula and Kalispell.
- HMHB with Donald Espelin, M.D., to serve as technical advisor;
- HMHB with R.A. Howard and Associates, a Montana Public Relations Firm, to provide support for all media elements and public relations elements;
- HMHB with Continental Productions in Great Falls to produce and distribute all video campaign elements;
- HMHB with the Utah Department of Health and KUTV in Salt Lake City to acquire all materials used in the Utah "Baby Your Baby" campaign;
- HMHB and R.A. Howard and Associates with the Montana Broadcasters' Association to provide distribution and support for the radio PSA campaign.

Additional contracts will be developed with successful respondents to bids for printed materials for the campaign.

Public Service Announcements (PSA) are being developed, with one running during each 6-month segment or "wave".

Twenty-six news segments have been filmed, with airing scheduled to begin in January, 1991.

An additional 26 news segment topics have been identified and are being researched.

Documentary topics for each half-hour documentary (one during each "wave") have been determined, and the script for the initial program is written. Printed materials will utilize many of the "camera ready" materials purchased from Utah. Others specific to Montana and Montana's problems will be developed.

Information packets have been "field tested" at the Florence Crittenton Home in Helena.

The 1-800-421-MOMS number has been put in place. A "registration form" to enroll women in the BYB program has been developed. Protocols for handling telephone inquiries are being developed.

Community forums held in 15 cities in Montana in November and December of 1990 served to inform health care and social service providers, local policy makers and others about the program. Even more important, the forums served to assist communities in developing local activities and referral services for the BYB campaign. Other forums are scheduled to be held during 1991.

An evaluation plan has been developed and will capture information relevant to ongoing planning by HmHb and the State of Montana and its health care and social service providers.

RECOMMENDATIONS OF THE

M I A M I ADVISORY COUNCIL

1. Extend the sunset on MIAMI legislation to June 30, 1993.

2. Create a state center for health statistics which will facilitate the retrieval of information needed to guide health provision and planning.

3. Develop a rural health planning commission, which will provide support and consultation to rural health practitioners, as well as guide state planning for rural health provision.

4. Encourage policy changes which will improve health care of infants and pregnant women through tort reform.

5. Support the Montana Medical Genetics Program.

6. Support the public vaccine program so that no child will be denied vaccine, and potentially pass preventable illnesses on to women and/or their fetuses.

7. Facilitate the creation of a central registry and tracking system for infants who have a high risk of experiencing developmental delay.

LOW BIRTHWEIGHT PREVENTION

8. Accommodate increased client loads by additional funding to the existing seven (7) low birthweight prevention projects.

9. Contingent on adequate funding of existing projects, fund an additional nine (9) low birthweight prevention project sites.

10. Facilitate the role of mid-level health care providers in Montana.

11. Collaborate with Indian Health Services, tribal health and urban Indian centers to improve coordination of services to Native Americans.

12. Facilitate home visits for all high risk and/or first time mothers.

13. Increase referrals of Low Birthweight Prevention Project clients to local family planning clinics and other applicable services.

INFANT MORTALITY REVIEW

14. Expand infant mortality review to additional sites, including more location where Native American populations may be accessed.

15. Fund expansion of the review process to include low birthweight births, to allow examination of causes of infant morbidity.

MEDICAID CHANGES FOR PREGNANT WOMEN

16. Expand Medicaid eligibility coverage for pregnant women and children up to age six to 185 percent of the federal poverty level.

17. Increase reimbursement for prenatal and delivery services to 90% of actual fee.

18. Implement a targeted case management system for high risk pregnant women.

19. Maintain presumptive and continuous eligibility as a Medicaid priority.

20. Support low cost health insurance packages which include maternity and well-child services.

PUBLIC EDUCATION

21. Promote public education of perinatal issues through the media, especially in the form of the Baby Your Baby campaign.

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APPENDICES

APPENDIX A

RISK ASSESSMENT OF PRETERM DELIVERY

Score	INITIAL SCREEN *Circle numbers that apply.*
1	2 or more children at home
3	8 years or less completed education
1	9-11 years high school, no degree
1	Less than 18 years old, not in school
4	Less than 17 years old
2	18-19 years old
2	Greater than 40 years old
2	Single parent
3	Less than 5 feet tall
3	Less than 100 pounds
1	Work outside home
3	Heavy physical or stressful work (patient's perception)
3	Greater than 30 minutes commute to work
2	Smokes more than 10 cigarettes a day or uses chewing tobacco

PAST HISTORY

1	Only 1 miscarriage/abortion less than 14 weeks
2	2 miscarriages/abortions less than 14 weeks
3	3 or more miscarriages/abortions less than 14 weeks
5	1 miscarriage/abortion more than 14 weeks
10	Repeated miscarriages/abortions more than 14 weeks
10	Premature labor, premature delivery or birth weight under 5 lbs. 8 oz.
5	2 or more previous stillbirths or early deaths
1	Less than one year since last birth
3	Cervical surgery
4	Kidney infection or more than 3 urinary tract infections
5	Uterine anomaly (except myoma) or DES exposure
3	History of placenta previa or abruptio
5	Cyanotic heart disease or renal failure

____ Total Score (A)

Risk of preterm delivery (circle one)

3 - High	2 - Medium	1 - Low
(>10)	(6 - 9)	(<5)

Date of Scoring ____ ____ ____
mo. day year

Score	REPEAT SCREEN (24-26 wks) CURRENT PREGNANCY
1	> 2 lb. weight loss/month in 2nd trimester
3	Total weight loss of 5 lb. by 26 weeks
2	Total weight gain < 8 lb. by 26 weeks
2	Persistent albuminuria > trace
2	Bacteriuria
5	Pyelonephritis in this pregnancy
3	Febrile illness
2	Hypertension > 120/80 in 2nd trimester
10	Hemoglobinopathies (SS, SC, other)
3	Anemia < 9 g
2	First trimester bleeding
4	Second trimester bleeding
4	Engaged head at 26 weeks
4	Effacement > 20% at 26 weeks
4	Dilation of internal os
5	Placenta previa (after 22 wks with bleeding)
10	Polyhydramnios (confirmed by ultrasound)
5	Oligohydramnios (confirmed by ultrasound)
3	Large uterine fibroids (>5 cm)
10	Multiple gestation
10	Abdominal surgery in this pregnancy

____ Total Score (B)

COMMENTS: _____

_____

_____

____ Total Score (A + B)

Risk of preterm delivery (circle one)

3 - High	2 - Medium	1 - Low
(>10)	(6 - 9)	(<5)

Date of Scoring ____ ____ ____
mo. day year

Other Clinical Data:

1. Genital Infection (Chlamydia, Herpes, etc.)
2. Alcohol/Drug Abuse
3. Other (Uterine irritability)

County of Residence _____ Date of First Prenatal Visit _____

Estimated Date of Confinement: Original _____ Revised _____ / G____ T____ P____ A____ L____

PHYSICIAN/ADDRESS: _____

_____

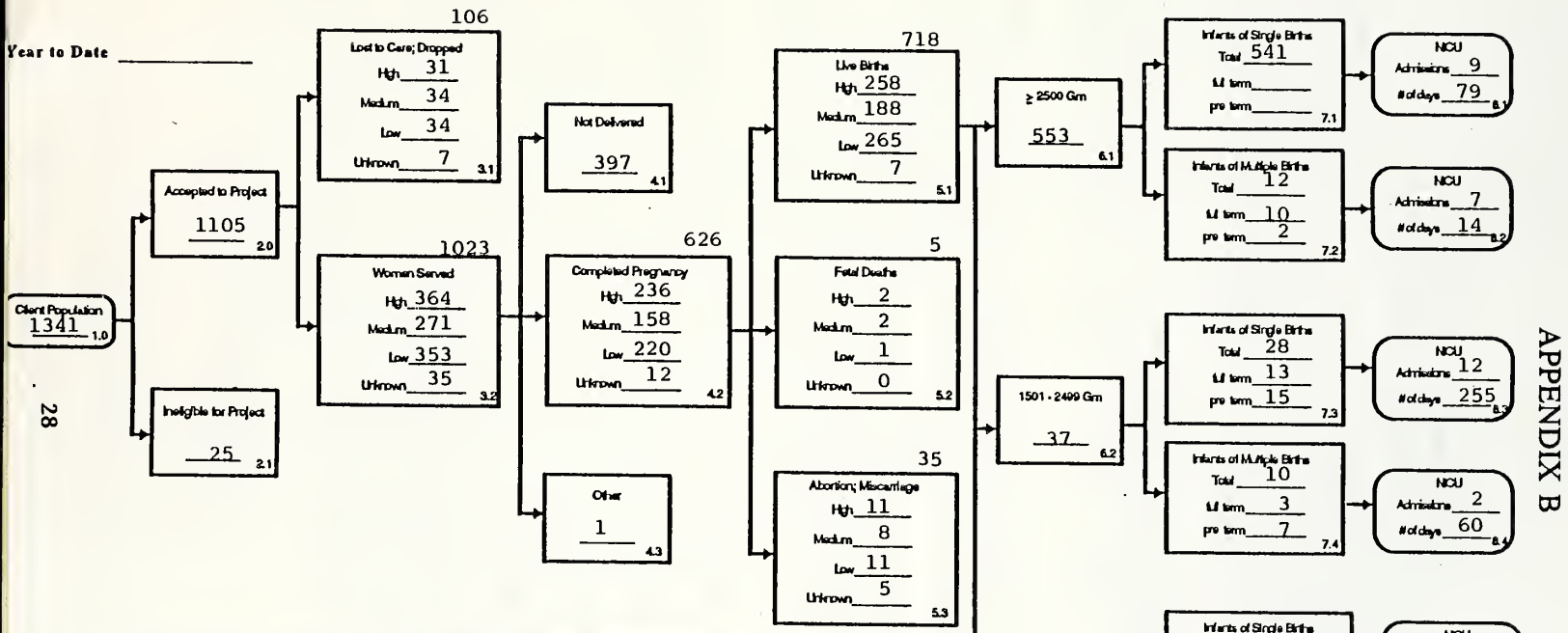
Delivery Information: Birth Weight _____ Apgar Score (1) _____ Sex: Male 1 Female 2

Date of Birth: _____ _____ _____ Method of Delivery: Cesarean 1 Vaginal 2

CLINICAL ESTIMATION OF GESTATIONAL AGE _____

Patient Name _____ Date of Birth _____ Race: White 1 Native American 2 Other 3

LOW BIRTHWEIGHT PROJECTS
YEAR END TOTALS
JULY 1, 1989 to JUNE 30, 1990



MONTANA LOW BIRTHWEIGHT PREVENTION PROJECTS PATIENT FLOWCHART

Project Name: _____

Location: _____

Reporting Period: _____

Submitted by: _____

Date: _____

Expected Outcome	Actual Outcome

APPENDIX B

APPENDIX C

Part 3

Montana Initiative for the Abatement of Mortality in Infants

Part Compiler's Comments

Appropriation Coordination — Void Without Appropriation: Section 12, Ch. 649, L. 1989, provided: "[This act] is void unless an appropriation for the administration of [this act] is specifically made to the department of health and environmental sciences in House Bill No. 100."

The appropriation narrative for item 8, Preventive Health, of the appropriation to the Department of Health and Environmental Sciences in House Bill No. 100 stated that item 8 included an appropriation to fund the MIAMI program.

Effective Date: Section 16, Ch. 649, L. 1989, provided that this part is effective July 1, 1989.

50-19-301. *(Temporary)* **Short title.** This part may be cited as "The Montana Initiative for the Abatement of Mortality in Infants (MIAMI) Act". *(Terminates June 30, 1991—sec. 15, Ch. 649, L. 1989.)*

History: En. Sec. 1, Ch. 649, L. 1989.

50-19-302. *(Temporary)* **Purposes.** The purposes of this part are to:

(1) assure that mothers and children, in particular those with low income or with limited availability of health services, receive access to quality maternal and child health services;

(2) reduce infant mortality and the number of low birthweight babies; and

(3) prevent the incidence of children born with chronic illnesses, birth defects, or severe disabilities as a result of inadequate prenatal care. *(Terminates June 30, 1991—sec. 15, Ch. 649, L. 1989.)*

History: En. Sec. 2, Ch. 649, L. 1989.

50-19-303. *(Temporary)* **Definitions.** For purposes of this part, the following definitions apply:

(1) "Council" means the MIAMI project advisory council established in 2-15-2109.

(2) "Department" means the department of health and environmental sciences provided for in 2-15-2101.

(3) "Low income" means, with respect to an individual or family, income that does not exceed the official federal poverty threshold as defined by the federal office of management and budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

(4) "Project" means the MIAMI project established in 50-19-311.

(5) "Service provider" means a person, agency, or organization that has a contract to provide services under the MIAMI project. *(Terminates June 30, 1991—sec. 15, Ch. 649, L. 1989.)*

History: En. Sec. 3, Ch. 649, L. 1989.

50-19-304 through 50-19-310 reserved.

50-19-311. *(Temporary)* **MIAMI project.** (1) There is a MIAMI project established in the department.

(2) Under the project, the department shall provide the following services:

(a) infant mortality review;

(b) low birthweight prevention;

(c) assistance to low-income women and infants in gaining access to prenatal care, delivery, and postpartum care;

(d) referral of low-income women and children to other programs to protect the health of women and children, including:

(i) supplemental food programs for women, infants, and children;

(ii) family planning services; and

(iii) other maternal and child health programs;

(e) public education and community outreach to inform the public on:

(i) the importance of receiving early prenatal care;

(ii) the need for good health habits during pregnancy; and

(iii) the availability of special services for pregnant women and for children. *(Terminates June 30, 1991—sec. 15, Ch. 649, L. 1989.)*

History: En. Sec. 4, Ch. 649, L. 1989.

50-19-312. *(Temporary)* **Advisory council — powers and duties.** The council shall:

(1) advise the department on matters relating to administration of the MIAMI project;

(2) review and monitor activities conducted under the project;

(3) gather information relating to infant mortality and low birthweight babies;

(4) identify problems in the quality and availability of maternal and child health services; and

(5) make recommendations to improve maternal and child health services consistent with the purposes of this part. *(Terminates June 30, 1991—sec. 15, Ch. 649, L. 1989.)*

History: En. Sec. 6, Ch. 649, L. 1989.

50-19-313 through 50-19-320 reserved.

50-19-321. *(Temporary)* **Contracts for services.** (1) The department shall contract with service providers to provide services under the MIAMI project.

(2) In selecting service providers, the department shall take into consideration the past performance of the person, agency, or organization in providing similar services, the demonstrated effectiveness of the service provider in delivering comparable or related services, the fiscal accountability of the service provider, and such other factors as the department determines to be appropriate. *(Terminates June 30, 1991—sec. 15, Ch. 649, L. 1989.)*

History: En. Sec. 7, Ch. 649, L. 1989.

50-19-322. *(Temporary)* **Federal and other aid.** (1) The department may apply for and receive federal aid and other funding available for the MIAMI project.

(2) Federal funds and other funding as may be available are appropriated to the department for use in administering the provisions of this part. *(Terminates June 30, 1991—sec. 15, Ch. 649, L. 1989.)*

History: En. Sec. 8, Ch. 649, L. 1989.

50-19-323. *(Temporary)* **Coordination of programs.** The department shall coordinate services under the MIAMI project with other services and programs in the state including:

(1) the early and periodic screening, diagnosis, and treatment services program under Title XIX of the federal Social Security Act;

(2) the Montana medicaid program established in 53-6-101; and

(3) programs administered with funds under the federal Maternal and Child Health Services Block Grant Act, Public Law 97-35, as may be amended. *(Terminates June 30, 1991—sec. 15, Ch. 649, L. 1989.)*

History: En. Sec. 9, Ch. 649, L. 1989.

2-15-2109. *(Temporary)* **MIAMI project advisory council.** (1) There is a Montana initiative for the abatement of mortality in infants (MIAMI) project advisory council.

(2) The council is composed of seven members appointed by the governor as follows:

(a) one person from the department who is involved in providing preventative health services for women and children;

(b) one person from the department of social and rehabilitation services who administers or supervises services under the Montana medicaid program;

(c) one person from a local health department;

(d) one person from among local service providers;

(e) one person representing a nonprofit child health organization;

(f) one private physician who specializes in obstetric or pediatric care; and

(g) one person involved in children's issues or programs who is a representative of a parents' organization.

(3) The council is allocated to the department for administrative purposes only as provided in 2-15-121.

(4) The provisions of 2-15-122(5) through (8) apply to the council and its members. *(Terminates June 30, 1991—sec. 15, Ch. 649, L. 1989.)*

History: En. Sec. 5, Ch. 649, L. 1989.

Compiler's Comments

Effective Date: Section 16, Ch. 649, L. 1989, provided that this section is effective July 1, 1989.

Cross-References

Montana Initiative for the Abatement of Mortality in Infants (MIAMI) Act, Title 50, ch. 19, part 3.

Duties of Advisory Council, 50-19-312.

APPENDIX D

TERMS AND DEFINITIONS

LOW BIRTHWEIGHT	LBW -- Less than 2,500 grams or 5.5 pounds
VERY LOW BIRTHWEIGHT	VLBW -- Less than 1,500 grams or 3.3 pounds
LOW BIRTHWEIGHT PREVENTION PROJECT	LBWPP - Community-based project located in either a local health department or hospital under contract with DHES to provide care coordinated services to at-risk pregnant women.
CARE COORDINATION	The system of care provided by the Low Birthweight Prevention Projects, including case management, education, empowerment, direct care provision, and other services necessary to result in healthy pregnancy and delivery of normal birth weight babies
INFANT MORTALITY REVIEW	IMR -- A process for examining factors which contribute to infant death through a systematic evaluation of individual cases in order to identify potential opportunities to improve maternal and infant health.
INFANT DEATH	The death of a person under one year of age
NEONATAL DEATH	The death of an infant under 28 days of age
POSTNEONATAL DEATH	The death of an infant aged 28 days - 1 year
FETAL DEATH	The birth of a fetus after 20 weeks of gestation which shows no evidence of life after complete birth
RESIDENCE	For death, this refers to the usual residence of the decedent. For births and fetal deaths, it refers to the usual residence of the mother.
OCCURRENCE	Where an event takes place regardless of the usual residence of the person involved.
CONTINUOUS ELIGIBILITY	Allows Medicaid eligibility to continue in cases where the pregnant woman would no longer be eligible for financial assistance based on a change in income.
PRESUMPTIVE ELIGIBILITY	Allows qualified providers to certify Medicaid eligibility for pregnant women while a formal application is being processed.
HEALTHY MOTHERS, BABIES	HMHB -- Private organization of health professionals, HEALTHY consumers and others who provide advocacy for maternal and child health issues
BABY YOUR BABY	BYB -- The public education campaign chosen by the MIAMI project; HMHB contracts with DHES to provide this campaign.
DHES	Montana Department of Health and Environmental Sciences
DSRS	Montana Department of Social and Rehabilitation Services

APPENDIX E

SELECTED MONTANA 1990 AND YEAR 2000 NATIONAL OBJECTIVES FOR MATERNAL AND INFANT HEALTH

LOW BIRTHWEIGHT

MONTANA - By 1990, low birth weight babies in Montana (5 ½ pounds and under) should constitute no more than 2.8 per cent of all live births.

NATIONAL - Reduce low birth weight to an incidence of no more than 5 percent of live births and very low birth weight to no more than 1 per cent of live births.

NATIVE AMERICAN

MONTANA - By 1990, no Montana county and no racial or ethnic group in Montana should have a rate of low birthweight infants that exceeds 3 percent of all live births.

INFANT MORTALITY

MONTANA - By 1990, Montana's infant mortality rate should be reduced to no more than 6 deaths per 1,000 live births.

NATIONAL - Reduce the infant mortality rate to no more than 7 per 1,000 live births.

NATIVE AMERICAN

MONTANA - By 1990, no Native American populace in Montana should have an infant mortality rate or fetal mortality rate in excess of the corresponding Caucasian rates.

NATIONAL - Year 2000 target: 8.5 per 1,000 live births.

NEONATAL MORTALITY

MONTANA - By 1990, the neonatal death rate in Montana should be reduced to no more than 3 deaths per 1,000 live births.

NATIONAL - Year 2000 target: 4.5 per 1,000 live births.

POSTNEONATAL MORTALITY

NATIONAL - Year 2000 target: 2.5/1,000 live births; American Indians: 4/1,000 live births.

EARLY PRENATAL CARE

MONTANA - By 1990, in Montana, the proportion of women in any county or racial or ethnic group who obtains no prenatal care during the first trimester of pregnancy should not exceed 5 percent.

NATIONAL - Increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy.

DEPARTMENT OF HEALTH AND
ENVIRONMENTAL SCIENCES